HIV/AIDS Monitoring Report

Department of Health and Human Services

Data through June 30, 2003

The mission of the City of Long Beach Department of Health and Human Services is to improve the quality of life of the residents of Long Beach by addressing the public health and human service needs ensuring that the conditions affecting the public's health afford a healthy environment in which to live, work and play.

HIV Reporting: A Year Later

A year has passed since California mandated the reporting of HIV infection. In that year, 58 county and three city health jurisdictions identified **20,943** HIV cases, according to the State Office of AIDS, including **819** cases of HIV reported in Long Beach. With four percent of all the State's reported HIV cases, Long Beach was surpassed in reported HIV cases by six other health jurisdictions, each much larger in size and population.

During this same period (i.e., July 1, 2002 – June 30, 2003), there was an increase in the number of AIDS cases reported to Long Beach's HIV Epidemiology Program. These are not new AIDS cases, but are cases that were not reported in the past, and were identified now due to more comprehensive surveillance practices for both HIV and AIDS.

When laboratories receive a specimen that indicates a confirmed positive HIV test result, the laboratory sends the local health department the confirmed result, the patient's encoded last name (soundex), the patient's date of birth, and date the test was performed. HIV Epidemiology staff match the soundex and date of birth with the local database to see if the individual has been previously reported. If not, the staff will make an appointment with the provider to either review the medical chart to report the case or give a presentation to the provider on how they can report the individual and all future positive cases. The latter is passive reporting, and providers must do so within seven days of diagnosis. The former is active reporting: an alternative that is utilized by many providers with the understanding that all collected information is confidential and is treated as such.

Long Beach's success with improved HIV/AIDS surveillance is attributed largely to cooperation by health care providers and laboratories, as well as to active, rather than passive reporting. Even so, there continues to be many challenges in HIV reporting. For example, despite conducting HIV reporting trainings, mass mailings and media coverage, many health care providers are still not aware that HIV reporting is State mandated, or if they are aware, do not consider it a priority. Also, there is a mistaken belief that the new

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Health Insurance Portability and Accountability Act (HIPAA) negates reporting requirements. However, Section 2500 California Code of Regulations, Title 17 permits disclosure of health information to the local health department without needing the prior consent of the patient. The process is still new and it will take time before HIV reporting is as commonplace as that for other communicable diseases.

Helpful Tip: *A valuable tool for health care providers is to keep a log of positive cases that link laboratory and soundex information to the names of infected individuals, therefore making it easier to track down a medical chart that is necessary for reporting.*

HIV EPIDEMIOLOGY PROGRAM

Introduction

Comprising nearly 50 square miles at the southernmost end of Los Angeles County, Long Beach has approximately a half-million residents, making it the fifth largest city in California and the 32nd largest in the United States (based on U.S. Census 2000). One of 61 health jurisdictions in California, the City of Long Beach has maintained the Health Department for more than 90 years.

Its size, diversity and geographic location in a major population center have made Long Beach particularly vulnerable to HIV and AIDS. With a cumulative incidence rate of 981.54 AIDS cases per 100,000 residents (1981 through June 30, 2003), Long Beach's AIDS incidence rate per capita is 100 percent higher than the incidence rate for all of Los Angeles County (487.87 cases per 100,000) and more than double the rate for the State of California overall (387.75 cases per 100,000), indicating that AIDS continues to be a significant public health issue in the City of Long Beach (Table 1).

TABLE 1
COMPARISON OF CITY OF LONG BEACH, LOS ANGELES COUNTY AND CALIFORNIA CUMULATIVE AIDS INCIDENCE RATE PER 100,000 POPULATION, 1981 THROUGH JUNE 30, 2003.

	2000 Population	Number of AIDS Cases	Cumulative AIDS Incidence Rate
City of Long Beach	461,522	4,530	981.54
Los Angeles County	9,519,338	46,442	487.87
California	33,871,648	131,336	387.75

Sources: California HIV/AIDS Reporting System, June 30, 2003
Long Beach HIV/AIDS Reporting System, June 30, 2003

The California Code of Regulations, Title 17, Section 2500, requires that all diagnosed or suspected cases of AIDS as defined by the Centers for Disease Control and Prevention (CDC) be reported within seven days to the local Health Officer. To facilitate reporting, the City of Long Beach Department of Health and Human Services maintains an HIV Epidemiology Program (funded by the State of California Department of Health Services Office of AIDS) which is responsible for collecting, analyzing and disseminating AIDS data.

Cumulative Cases

Since its first AIDS case report in February 1983, a cumulative total of 4,530 AIDS cases has been reported in Long Beach through June 30, 2003. The cumulative case fatality rate of 55% percent is lower than California (60%) and Los Angeles County (61%). Of the 4,530 reported AIDS cases, 2,052 people are currently living.

Race/Ethnicity

Of the 4,530 cumulative AIDS cases, approximately two-thirds (61.0%) are White (Table 2). While Whites still comprise the majority of the reported cases, the number of HIV infections may be decreasing in this group. From July 2002 through June 2003, the percentage of AIDS cases reported in Whites was 47.0 percent. AIDS cases in Blacks, while contributing 17.5 percent to the cumulative cases, comprised 20.1 percent of the cases reported in the past year. Hispanic AIDS cases comprised more than one-quarter (30.1%) of the cases reported in the last year, yet they make up 19.3 percent of the cumulative cases. The percentage of cases among Asian/Pacific Islanders during the past year (1.6%) is less than the 1.9 percent reported cumulatively (Table 2).

Table 2
Cumulative AIDS Cases by Race/Ethnicity and Percent of Population Reported 1981 through June 30, 2003, City of Long Beach

	2000 Population	Percent of Population	Number of AIDS Cases	Percent of AIDS Cases
White, Not Hispanic	152,899	33.1%	2,760	61.0%
Black, Not Hispanic	66,836	14.5%	791	17.5%
Hispanic	165,092	35.8%	876	19.3%
Asian/PI	60,329	13.1%	84	1.9%
Amer.Ind./Alaska Nat.	2,785	1.0%	13	0.3%
2 or More Races	13,581	2.9%	5	0.1*
Not Specified			1**	<0.1%
TOTAL	461,522	100%	4,530	100%

* Collection for 2 or more races began January 1, 2003
** These cases are pending investigation. Upon identification of race/ethnicity,

Gender

The vast majority of AIDS cases in Long Beach are male (93.6 percent). However, the increasing percentage of female AIDS cases being reported each year suggests that more women may be becoming infected. During July 1, 2002 - June 30, 2003, 8.4 percent of the cases reported were in females, compared with a cumulative percentage of 6.4 for cases reported as of June 30, 2003 (Table 3).

Age

Table 3
AIDS Cases by Report Date and Gender, Reported July 1, 2002 through June 30, 2003, and Cumulative Totals through June 30, 2003, City of Long Beach.

	July 2002 – June 2003	1981 – July 2003
Male	336 (91.1%)	4,240 (93.6%)
Female	33 (8.9%)	290 (6.4%)
TOTAL	369 (100%)	4,530 (100%)

Through June 30, 2003, almost half (48.0%) of the cumulative AIDS cases in Long Beach were diagnosed among people between the ages of 30 and 39. More than one-quarter of all cases were diagnosed among people between the ages of 40 and 49. This indicates that the majority of people with AIDS in Long Beach were infected in young adulthood. Fifteen percent of AIDS cases were diagnosed in people in their twenties, suggesting that a significant number of people with AIDS became infected during adolescence (Table 4).

Table 4
Cumulative AIDS Cases by Age Group and Gender, Reported 1981 through june 30, 2003, City of Long Beach.

	No. of Male Cases	No. of Female Cases	TOTAL
Under 13	5 (0.1%)	4 (1.4%)	9 (0.2%)
13-19	12 (0.3%)	7 (2.4%)	19 (0.4%)
20-29	623 (14.7%)	68 (23.4%)	691 (15.3%)
30-39	2,055 (48.5%)	120 (41.4%)	2,175 (48.0%)
40-49	1,113 (26.3%)	61 (21.0%)	1,174 (25.9%)
Over 49	432 (10.2%)	30 (10.3%)	462 (10.2%)
TOTAL	4,240 (100%)	290 (100%)	4,530 (100%)

Exposure Category

Almost eighty percent of all adult male AIDS cases reported through June 30, 2003 in Long Beach reported male-to-male sexual contact (MSM) as a mode of transmission. An additional 9.6 percent reported both male-to-male sexual contact and injection drug use (IDU). Seven percent of male AIDS cases reported injection drug use as the sole risk behavior. Over one percent of male cases report being infected through heterosexual contact (Table 5).

Among women in Long Beach, however, heterosexual contact and injection drug use are the prevalent modes of HIV transmission. Of all adult female AIDS cases reported in Long Beach, 54.0 percent were infected through heterosexual contact. Thirty-five percent were infected through injection drug use. About three percent were infected through the receipt of blood transfusions or blood components, while the remaining cases (6.3%) have reported no risk or are currently under investigation (Table 6).
The predominant mode of HIV exposure in children is perinatal transmission (88.9%) (Table 7).

Table 5
Cumulative Adult Male AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through June 30, 2003, City of Long Beach.

	White	Black	Hispanic	Asian/PI	Am. I./Al. Nat.	Multi-race	Unk.	TOTAL (Row%)
Sex between men	2,253	428	617	67	7	3	1	3,376 (79.7%)
Sex between men/IDU	256	77	67	1	4	0	0	405 (9.6%)
Injection Drug Use	125	116	58	0	0	0	0	299 (7.1%)
Heterosexual Contact	21	26	27	3	0	0	0	77 (1.8%)
With IDU	*4*	*6*	*1*	*0*	*0*	*0*	*0*	*11*
With Transfusion Recipient	*0*	*0*	*2*	*0*	*0*	*0*	*0*	*2*
With Person with HIV/AIDS	*17*	*20*	*24*	*3*	*0*	*0*	*0*	*64*
Transfusion	6	2	5	1	0	0	0	14 (0.3%)
Adult Hemophilia	9	1	0	1	0	0	0	11 (0.3%)
Pediatric Hemophilia	1	0	1	0	0	0	0	2 (<0.1%)
Risk Not Reported	17	14	17	3	0	0	0	51 (1.2%)
TOTAL (Column %)	2,688 (63.5%)	664 (15.7%)	792 (18.7%)	76 (1.8%)	11 (0.3%)	3 (<0.1%)	1 (<0.1%)	4,235 (100%)

Table 6
Cumulative Adult Female AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through June 30, 2003, City of Long Beach.

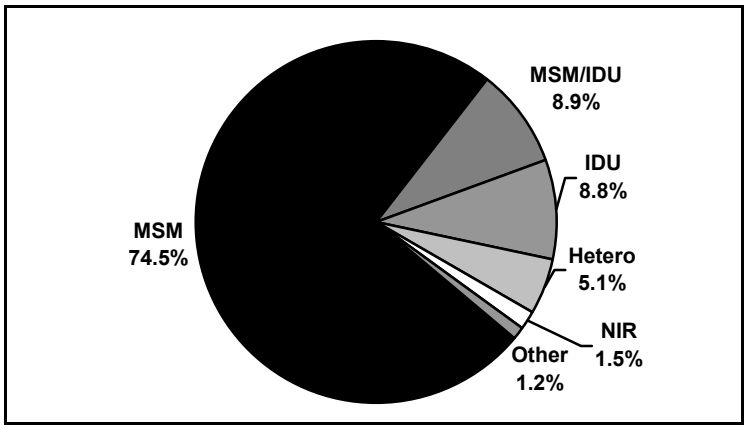
	White	Black	Hispanic	Asian/PI	Multi-race	Other/Unk.	TOTAL (Row %)
Injection Drug Use	28	53	19	0	0	1	101 (35.3%)
Heterosexual Contact	33	57	56	7	2	0	154 (54.0%)
With Bisexual Male	*6*	*1*	*2*	*0*	*0*	*0*	*9*
With IDU	*8*	*16*	*10*	*1*	*0*	*1*	*36*
With Transfusion Recipient	*0*	*0*	*0*	*2*	*0*	*0*	*2*
With Hemophiliac	*0*	*1*	*1*	*0*	*0*	*0*	*2*
With Person with HIV/AIDS	*19*	*39*	*43*	*4*	*2*	*0*	*107*
Transfusion	5	3	1	1	0	0	9 (3.1%)
Pediatric Hemophilia	0	1	0	0	0	0	1 (0.3%)
Risk Not Reported	4	10	4	0	0	0	18 (6.3%)
TOTAL (Column %)	70 (24.5%)	124 (43.4%)	80 (28.0%)	8 (2.8%)	2 (0.7%)	1 (0.3%)	286 (100%)

Table 7
Cumulative Pediatric AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through June 30, 2003, City of Long Beach.

	White	Black	Hispanic	TOTAL (Row %)
Mother with Risk	1	3	4	8 (88.9%)
Transfusion	1	0	0	1 (11.1%)
TOTAL (Column %)	2 (22.2%)	3 (33.3%)	4 (44.4%)	9 (100%)

Combined, about three-quarters (74.5%) of Long Beach AIDS cases report sex between men as a risk factor. Almost nine percent report intravenous drug use. Another nine percent report both sex between men and injection drug use. Five percent of Long Beach cases report heterosexual contact as the sole risk. Slightly more than one percent of AIDS cases in Long Beach are the result of a blood/blood product transfusion or pediatric transmission. The remaining cases did not report a risk or are currently under investigation to elucidate possible modes of transmission further (Figure 1).

Figure 1
Cumulative AIDS Cases by Exposure Category, Reported 1981 through June 30, 2003, City of Long Beach.



Total Cases = 4,530
Other = Transfusion or transplant recipient, hemophilia, and pediatric cases.

AIDS Defining Conditions

The AIDS surveillance system represents cases that have met the AIDS case surveillance reporting criteria established by the CDC. In 1993, the AIDS surveillance case definition was expanded to include a laboratory measure of severe immunosuppression (CD4+ T-lymphocyte counts of less than 200 cells/µl or a percent of total lymphocytes less than 14), pulmonary tuberculosis, invasive cervical carcinoma, and recurrent bacterial pneumonia. Prior to 1993, the surveillance definition included only opportunistic illnesses.

Mortality Rates

Table 8 presents the annual and cumulative fatality rates of AIDS cases reported in Long Beach by the year of diagnosis. The presented rates are comparable to those of Los Angeles County, California, and the United States.

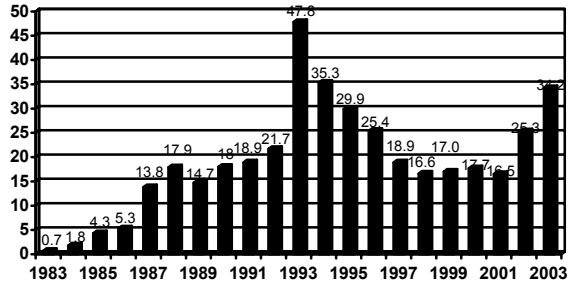
Table 8
AIDS Case Mortality by Year of Diagnosis, Reported 1981 through June 30, 2003, City of Long Beach.

Year	Diagnosed Cases	Deaths	Fatality Rate for Cases Diagnosed in Year	Cumulative Fatality Rate
Before 1990	865	823	—	98%
1990	297	263	89%	93%
1991	373	319	86%	92%
1992	417	330	79%	89%
1993	362	228	63%	85%
1994	312	159	51%	81%
1995	328	114	35%	76%
1996	293	69	24%	71%
1997	232	45	19%	68%
1998	197	35	18%	65%
1999	219	27	12%	62%
2000	215	33	15%	59%
2001	190	15	8%	57%
2002	185	16	9%	55%
2003	45	2	4%	55%
TOTAL	4,530	2,478	—	56%

Impact of Changes in the AIDS Case Definition

The surveillance definition of AIDS was modified in 1985, 1987 and 1993 to reflect increased knowledge of the manifestations of HIV disease. These expanded definitions present challenges in analyzing case trends. For example, expanding the surveillance case definition in 1993 to include HIV-infected individuals with CD4+ T-lymphocyte counts below 200 cells/µl resulted in a number of new cases being reported as well as with the implementation of HIV Reporting in July of 2002 (Figure 2).

Figure 2
Average Reported AIDS Cases per Month, Reported 1981 through June 30, 2003, City of Long Beach.



Survival Status

By analyzing the data presented in Table 9 and comparing relative proportions of the living and the deceased, changes in the local epidemiology of advanced HIV disease may be detected as living cases are representative of more recent infections. For instance, a higher number of Blacks (20.4%) and Hispanics (25.5%) are currently living with AIDS than are deceased (15.0% and 14.2%, respectively). This demonstrates a shift toward increasing HIV infections in minorities. Similar changes are seen in the gender, age, and exposure categories.

TABLE 9
AIDS CASES BY SURVIVAL STATUS AND DEMOGRAPHICS, REPORTED 1981 THROUGH JUNE 30, 2003, CITY OF LONG BEACH.

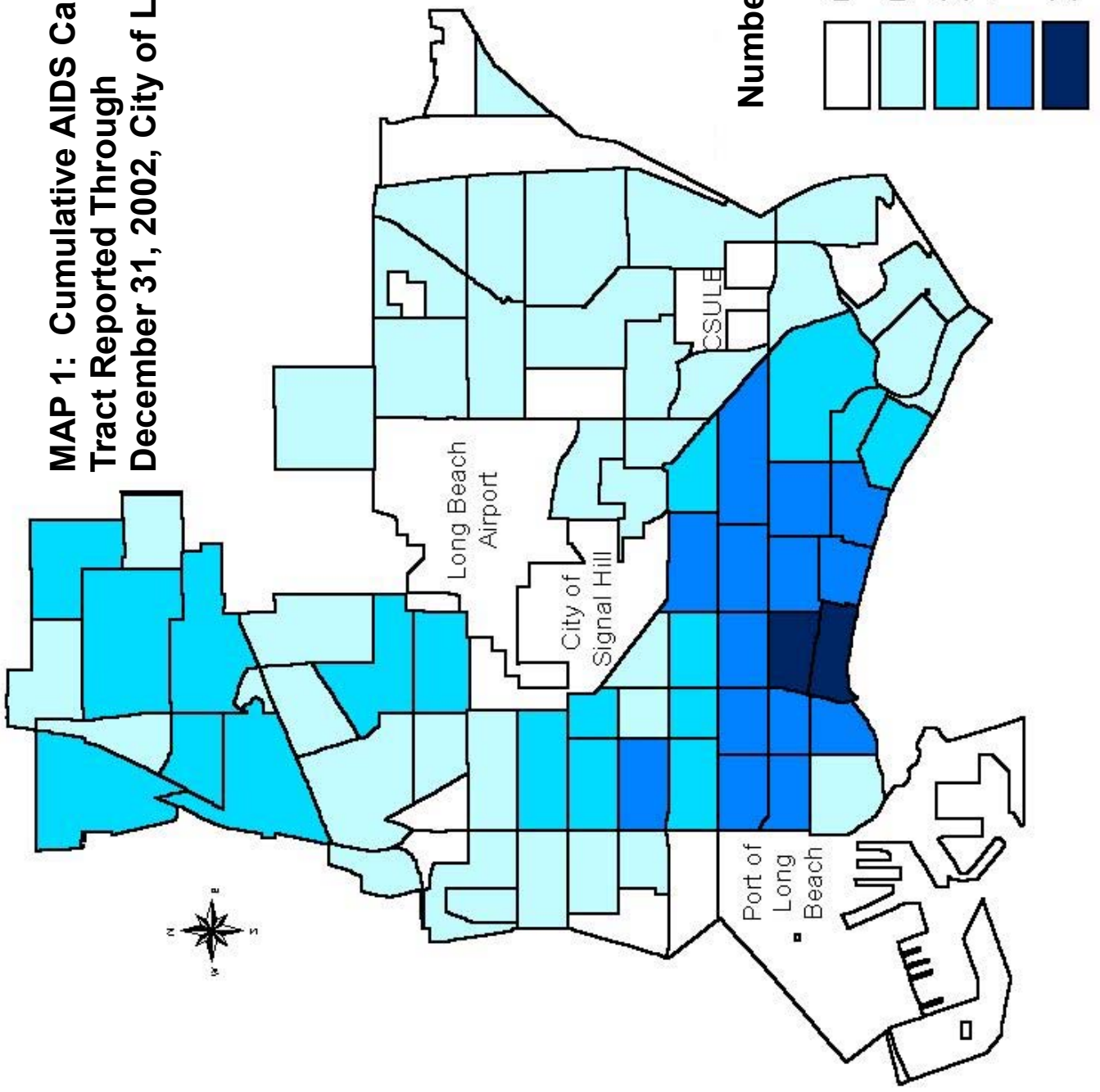
Case Profile	Living	Deceased
Gender		
Male	1,865 (91.2%)	2,370 (95.6%)
Female	181 (8.8%)	108 (4.4%)
Race/Ethnicity		
White, Not Hispanic	1,049 (51.3%)	1,707 (68.9%)
Black, Not Hispanic	418 (20.4%)	373 (15.0%)
Hispanic	521 (25.5%)	353 (14.2%)
Asian/PI	46 (2.2%)	38 (1.5%)
Am. Ind./Alaska Nat.	9 (0.4%)	4 (0.2%)
Multi-race	3 (0.1%)	2 (<0.1%)
Unknown	0 (0.0%)	1 (<0.1%)
Age		
Age <13	3 (0.1%)	6 (0.2%)
13-19	12 (0.6%)	7 (0.3%)
20-29	319 (15.6%)	371 (15.0%)
30-39	1005 (49.1%)	1,168 (47.1%)
40-49	541 (26.4%)	630 (25.4%)
50+	166 (8.1%)	296 (11.9%)
Exposure Category		
Sex between men	1,453 (71.0%)	1,921 (77.5%)
Sex between men/IDU	196 (9.6%)	207 (8.4%)
Injection Drug Use	197 (9.6%)	203 (8.2%)
Heterosexual Contact	158 (7.7%)	73 (2.9%)
Hemophilia	6 (0.3%)	8 (0.3%)
Transfusion	6 (0.3%)	19 (0.8%)
Perinatal Transmission	3 (0.1%)	5 (0.2%)
NIR	27 (1.3%)	42 (1.7%)
TOTAL	**2,046 (100%)**	**2,478 (100%)**

Geographic Information System

Geographic Information System (GIS) is a computer-based mapping technology, which combines geographical data and events such as a population, disease cases, vital statistics, socioeconomic indicators, and many other data sources to generate maps for spatial analysis. The Health Department uses GIS to monitor the health status of the community by assessing epidemiological data. This analysis determines which diseases and conditions account for the greatest morbidity and mortality in the City which allows for more localized efforts in health promotion and disease prevention efforts.

AIDS surveillance data is used to map cases by geographic location such as zip codes and census tracts in Long Beach. Geographic analysis of data allows for the provision of HIV/AIDS screening and prevention services to be targeted to individuals that are at a greater risk for infection. Mapping AIDS cases in the City may allow for a greater level of targeted outreach in the areas with a higher number of cases. Map 1 demonstrates the cumulative number of reported AIDS cases at time of diagnosis among City residents from 1981 through December 31, 2002 by census tract. This map does not take into the account the migration of individuals with AIDS moving in and out of Long Beach.

MAP 1: Cumulative AIDS Cases By Census Tract Reported Through December 31, 2002, City of Long Beach



Source: City of Long Beach Department of Health and Human Services, HIV Epidemiology Program.

HIV ANTIBODY TESTING PROGRAM

The Health Department provides both anonymous and confidential HIV antibody testing to the public. HIV antibody testing also occurs through other venues in the City of Long Beach, including private physicians, hospitals and clinics. These data reflect City-administered testing programs only.

The City has maintained data on both anonymous and confidential HIV antibody testing since the programs began. In January 1990, the California Department of Health Services, Office of AIDS implemented the HIV Test Reporting System, a computer program that collects demographics on clients and their test results to generate reports valid to local testing sites and to improve data reporting to the Office of AIDS.

"Data represents each client visit and services provided. The basic tabulated information is this client visit/service unit. A client may have made more than one HIV-related visit; each visit may be reported separately. A client may have received more than one service from different funding sources on the same visit — each reported separately. It is important to keep in mind that these data represent counseling and testing services through these programs and should NOT be interpreted as representing persons or the population of [Long Beach] in general. Recipients of these services are a highly self-selected group."

California HIV Testing and Counseling Monthly Report, 2/90

Anonymous Testing

The Alternative Test Site (ATS) program was developed for individuals wanting to know their HIV antibody status anonymously. The HIV antibody test administered in an ATS setting addressed the concern that individuals at risk for HIV infection might donate blood to determine their antibody status if blood banks were the only source of free and easily accessible testing. ATS began here in Long Beach in June 1985 and two testing sites currently exist (Table 12 and 13).

TABLE 12
ANONYMOUS HIV ANTIBODY TESTS BY RACE/ETHNICITY AND AGE GROUP, APRIL 1988 THROUGH JUNE 30, 2003, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Race/Ethnicity				
White	48,754	56.5%	1,684	3.5%
Black	11,999	13.9%	391	3.3%
Hispanic	18,741	21.7%	648	3.5%
Asian/PI	4,695	5.4%	78	1.7%
Am. Ind./Alaska Nat.	564	0.7%	33	5.9%
Other/Unknown	1,588	1.8%	37	2.3%
Age Group				
12-19	5,407	6.3%	39	0.7%
20-29	35,497	41.1%	1,051	3.0%
30-39	26,982	31.3%	1,170	4.3%
40-49	11,977	13.9%	448	3.7%
50-59	4,300	5.0%	123	2.9%
60+	2,122	2.5%	36	1.7%
Unknown	56	0.1%	4	7.1%
TOTAL	**86,341**	**100.0%**	**2,871**	**3.3%**

* Prior to April 1988, no testing data were collected by race/ethnicity or age group.

TABLE 13
ANONYMOUS HIV ANTIBODY TESTS BY GENDER AND EXPOSURE CATEGORY, JUNE 1985 THROUGH JUNE 30, 2003, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	70,400	67.7%	5,080	7.2%
Female	33,596	32.3%	196	0.6%
Other/Unknown	64	0.1%	0	0.0%
Exposure Category				
MSM	30,103	28.9%	3,975	13.2%
Bisexual	7,491	7.2%	594	7.9%
IDU	3,647	3.5%	94	2.6%
MSM/IDU	872	0.8%	146	16.7%
Hemophiliac	26	<0.1%	4	15.4%
Transfusion Recipient	1,423	1.4%	19	1.3%
Heterosexual	29,025	27.9%	149	0.5%
High Risk Sex Partner	17,346	16.7%	173	1.0%
Occupational	759	0.7%	2	0.3%
No Risk Stated	11,066	10.6%	66	0.6%
Unknown	2,302	2.2%	54	2.3%
TOTAL	**104,060**	**100.0%**	**5,276**	**5.1%**

Confidential Testing

Confidential testing (CTS) began in 1988; this report reflects data gathered beginning January 1989. These data include individuals tested confidentially for HIV antibody status at the Health Department or through special outreach testing efforts. The confidential testing report includes data collected from tests performed at Health Department clinics.

TABLE 14
CONFIDENTIAL HIV ANTIBODY TESTS BY DEMOGRAPHICS, JANUARY 1989 THROUGH JUNE 30, 2003, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	27,207	59.5%	466	1.7%
Female	18,378	40.2%	95	0.5%
Other/Unknown	105	0.2%	3	2.9%
Race/Ethnicity				
White	13,501	29.5%	181	1.3%
Black	14,931	32.7%	236	1.6%
Hispanic	12,648	27.7%	141	1.1%
Asian/PI	3,159	6.9%	14	0.4%
Am. Ind./Alaska Nat.	364	0.8%	4	1.1%
Other/Unknown	1,087	2.4%	10	0.9%
Age Group				
Under 12	18	<0.1%	0	0.0%
12-19	6,165	13.5%	13	0.2%
20-29	18,641	40.8%	192	1.0%
30-39	11,405	25.0%	240	2.1%
40-49	6,431	14.1%	103	1.6%
50-59	2,228	4.9%	26	1.2%
60+	720	1.6%	11	1.5%
Unknown	82	0.2%	1	1.2%
Exposure Category				
MSM	1,984	4.5%	176	8.9%
Bisexual	1,402	3.1%	86	6.1%
IDU	2,953	6.6%	61	2.1%
MSM/IDU	331	0.7%	50	15.1%
Hemophiliac	1	<0.1%	0	0.0%
Transfusion Recipient	250	0.6%	3	1.2%
Heterosexual	18,691	42.0%	76	0.4%
High Risk Sex Prtnr	9,907	22.2%	94	0.9%
Occupational	220	0.5%	0	0.0%
No Risk Stated	6,994	15.7%	33	0.5%
Unknown	1,810	4.1%	7	0.4%
TOTAL	**44,543**	**100.0%**	**586**	**1.3%**

TECHNICAL NOTES

These data reflect statistical monitoring activities aimed at identifying the entire range of HIV infection in Long Beach.

Data presented in this report are provisional due to reporting delays.

Surveillance and Reporting of AIDS[1]

The AIDS Classification System represents cases that have met the AIDS case surveillance reporting criteria established by the Federal Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services. In September 1992, the CDC proposed the inclusion of three conditions: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer, and HIV-infected adolescents and adults who have CD4+ T-lymphocyte counts less than 200 cells/µL or a CD4+ percentage of less than 14, in addition to the clinical conditions listed in the 1987 surveillance case definition. This revised classification was implemented in January 1993. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category only meet the 1993 definition.

Caution should be used when interpreting monthly statistics, because they can vary month to month due to a variety of factors. Therefore, looking at the long-term trends for a complete analysis of the AIDS data is necessary. Similar caution should be used in the interpretation of small numbers cases, as analyses based on small numbers are more likely to yield incorrect conclusions due to random or systematic error.

Age group tabulations are based on the person's age at diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Men who have sex with men (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

Heterosexual contact cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., injecting drug use).

Undetermined cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of transmission categories. These cases include: persons whose exposures are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Race/Ethnicity[2] is classified by the individual reporting the AIDS case. Usually, race/ethnicity is self reported by the patient upon enrollment with the health care provider. The definitions below represent those classifications as effectively as possible.

White, Not Hispanic: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Black, Not Hispanic: A person having origins in any of the black racial groups of Africa.

Hispanic: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

Asian/Pacific Islander: A person having origins in any of the original people of the Far East, South East Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.

American Indian/Alaska Native: A person having origins in any of the original peoples of North American, and who maintains cultural identification through tribal affiliation or community recognition.

Not Specified: Race/ethnicity was not identified and/or reported at the time of diagnosis and report. These cases are currently under investigation. Upon identification of race/ethnicity, cases will be reclassified into the appropriate category.

Incidence rate[3] is defined as the number of new cases of a specified disease diagnosed or reported during a defined period of time, divided by the number of persons in a state population in which the cases occurred. This is usually expressed as cases per 1,000 or 100,000 per annum. This rate may be expressed as age– or gender-specific or as specific for any other population characteristic or subdivision.

Prevalence rate[3] is defined as the total number of persons sick or portraying a certain condition in a stated population at a particular time, or during a stated period of time, regardless of when that illness or condition began, divided by the population at risk of having the disease or condition at the point in time or midway through the period in which they occurred.

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[1] Definitions used here were taken mostly from the CDC HIV/AIDS Surveillance Report, Technical Notes section.

[2] Federal Register. August 28, 1995. Volume 60, Number 166. Notices, pp. 44692-44693.

[3] Control of Communicable Diseases Manual. Abram S. Benenson, Editor. Sixteenth Edition, 1995.

HIV/AIDS RESOURCES

National Hotlines

AIDS Clinical Trials Information Services	800-TRIALS-A
CDC Hearing Impaired AIDS Hotline (TTY)	800-243-7889
CDC Labor Responds to AIDS Resource Service	800-458-5231
CDC National HIV/AIDS Hotline	800-342-AIDS
CDC Spanish HIV/AIDS Hotline	800-344-7432
CDC National Prevention Information Network	800-458-5231
CDC National STD Hotline	800-227-8922
AIDS Statistical Information Line (Recorded Information)	888-232-3299
Fax Information Service Line	888-232-3299
General Info. (including info on HIV/ AIDS) (Recorded Information)	888-232-3299
HIV/AIDS Treatment Information Service	800-HIV-0440
Project Inform (HIV Treatment Hotline)	800-822-7422
National Pediatric HIV Resource Center	800-362-0071

State AIDS Hotlines

California (Southern) (English)	800-922-AIDS
California (Southern) (Spanish)	800-400-SIDA
California (Northern) (Spanish and English)	800-367-AIDS
California (Northern) (Tagalog)	800-345-AIDS
California (Northern) (TDD)	888-225-AIDS

NOTICE TO HEALTH CARE PROVIDERS AND OTHERS RESPONSIBLE FOR DISEASE REPORTING

California Code of Regulations, Title 17, Section 2500 requires that all diagnosed or suspected cases of AIDS as defined by CDC must be reported within seven (7) days to the Health Officer. To obtain information on the CDC AIDS case definition, to obtain case report forms or to report a case, contact:

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815
Phone (562) 570-4311
www.longbeach.gov/health

Ronald R. Arias, M.P.A.
Director
Department of Health and Human Services

Darryl Sexton, M.D.
City Health Officer

Nettie DeAugustine, Manager
Preventive Health Bureau

John Holguin, Supervisor
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Christina Kau, Data Manager
Preventive Health Bureau

Single copies of this report are available free from the Long Beach Department of Health and Human Services, Preventive Health Bureau, HIV Epidemiology Program, 2525 Grand Avenue, Long Beach, CA 90815; telephone (562) 570-4311. This report is also available on the City of Long Beach Web Site at www.longbeach.gov/health.

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815

HE1207-04

Attention Health Care Providers

The California Code of Regulations, Title 17, Section 2500, requires the report of communicable diseases and conditions. To report a case of a communicable disease, contact the City of Long Beach Department of Health and Human Services Epidemiology Program at 562-570-4302 or by fax at 562-570-4374.

Reportable Communicable Diseases

HIV/AIDS)✉
Amebiasis)✉FAX
Anisakiasis)✉FAX
Anthrax ☎
Babesiosis)✉FAX
Botulism ☎
Brucellosis☎
Campylobacteriosis)✉FAX
Chancroid
Chlamydial Infections
Cholera ☎
Ciguatera Fish Poisoning ☎
Coccidioidomycosis
Colorado Tick Fever)✉FAX
Conjunctivitis, Acute Infectious of the Newborn)✉FAX
Cryptosporidiosis)✉FAX
Cysticercosis
Dengue ☎
Diarrhea of the Newborn ☎ (Outbreaks)
Diphtheria ☎
Domoic Acid Poisoning ☎
Echinococcosis
Ehrlichiosis
Encephalitis)✉FAX
Escherichia coli O157:H7 ☎
Foodborne Disease)✉FAX †
Giardiasis
Gonococcal Infections
Haemophilus Influenzae)✉FAX
Hantavirus Infections ☎
Hemolytic Uremic Syndrome ☎
Hepatitis, Viral)✉FAX
Kawasaki Syndrome
Legionellosis
Leprosy
Leptospirosis
Listeriosis)✉FAX
Lyme Disease
Lymphocytic Choriomeningitis)✉FAX
Malaria)✉FAX
Measles)✉FAX
Meningitis)✉FAX
Meningococcal Infections ☎
Mumps
Non-Gonococcal Urethritis
Paralytic Shellfish Poisoning ☎
Pelvic Inflammatory Disease
Pertussis (Whooping Cough))✉FAX
Plague, Human or Animal ☎
Poliomyelitis, Paralytic)✉FAX
Psittacosis)✉FAX
Q Fever)✉FAX
Rabies, Human or Animal ☎
Relapsing Fever)✉FAX
Reye Syndrome
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
Salmonellosis)✉FAX
Scombroid Fish Poisoning ☎
Shigellosis)✉FAX
Smallpox (variola) ☎
Streptococcal Infections)✉FAX (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
Swimmer's Itch)✉FAX
Syphilis)✉FAX
Tetanus
Toxic Shock Syndrome
Toxoplasmosis
Trichinosis)✉FAX
Tuberculosis)✉FAX
Tularemia ☎
Typhoid Fever)✉FAX (Cases and Carriers)
Typhus Fever
Varicella (deaths only) ☎
Vibrio Infections)✉FAX
Viral Hemorrhagic Fevers ☎
Water-associated Disease)✉FAX
Yellow Fever ☎
Yersiniosis)✉FAX
OCCURRENCE of ANY UNUSUAL DISEASE ☎
OUTBREAKS of ANY DISEASE ☎

Reportable Noncommunicable Diseases/Conditions

Alzheimer's Disease
Cancer
Disorders Characterized by Lapses of Consciousness

)✉FAX = Report by FAX, telephone, or mail within one (1) working day of identification.

† = Report immediately by telephone when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness.

☎ = Report immediately by telephone.
All other diseases/conditions should be reported by FAX, telephone, or mail within seven (7) calendar days of identification.